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| PREVAILED | Roll Call No. _____ |
| FAILED | Ayes _____ |
| WITHDRAWN | Noes _____ |
| RULED OUT OF ORDER | |

# HOUSE MOTION ____

MR. SPEAKER:

I move that Engrossed Senate Bill 276 be amended to read as follows:

Page 11, between lines 11 and 12, begin a new paragraph and insert:

"SECTION 4. IC 27-8-5-2.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 2.5. (a) As used in this section, the term "policy of accident and sickness insurance" does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Automobile medical payment insurance.

(4) A specified disease policy issued as an individual policy.

(5) A limited benefit health insurance policy issued as an individual policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement, without regard to the actual expense of the confinement.

(8) Worker's compensation or similar insurance.

(9) A student health insurance policy.

(b) The benefits provided by an individual policy of accident and sickness insurance may not be excluded, limited, or denied for more than twelve (12) months after the effective date of the coverage because of a preexisting condition of the individual.

(c) An individual policy of accident and sickness insurance may not define a preexisting condition, a rider, or an endorsement more

restrictively than as:

(1) a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the twelve (12) months immediately preceding the effective date of enrollment in the plan;

(2) a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of enrollment in the plan; or

(3) a pregnancy existing on the effective date of enrollment in the plan.

(d) An insurer shall reduce the period allowed for a preexisting condition exclusion described in subsection (b) by the amount of time the individual has continuously served under a preexisting condition clause for a policy of accident and sickness insurance issued under IC 27-8-15 if the individual applies for a policy under this chapter not more than thirty (30) days after coverage under a policy of accident and sickness insurance issued under IC 27-8-15 expires.

**(e) Notwithstanding subsections (b) and (c), an individual policy of accident and sickness insurance may contain a waiver of coverage for a specified condition and complications that arise from the specified condition if:**

**(1) the period for which the exemption would be in effect does not exceed five (5) years; and**

**(2) all of the following conditions are met:**

**(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage is being waived.**

**(B) The:**

**(i) offer of coverage; and**

**(ii) policy;**

**include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.**

**(C) The:**

**(i) offer of coverage; and**

**(ii) policy;**

**do not include more than two (2) waivers.**

**(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.**

**(E) The insurer agrees to:**

**(i) review the underwriting basis for the waiver upon request one (1) time per year; and**

**(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.**

**(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage and apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.**

**(G) The waiver of coverage does not apply to coverage required under state law.**

**The insurer shall require an applicant to initial the written notice provided under subdivision (2)(A) and the waiver included in the offer of coverage and in the policy under subdivision (2)(B) to acknowledge acceptance of the waiver of coverage. An offer of coverage under a policy that includes a waiver under this subsection does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.**

**(f) An insurer shall not, on the basis of a waiver contained in a policy as provided in subsection (e), deny coverage for any condition, complication, service, or treatment that is not specified as required in the:**

**(1) written notice under subsection (e)(2)(A); and**

**(2) offer of coverage and policy under subsection (e)(2)(B).**

**(g) An individual who is covered under a policy that includes a waiver under subsection (e) may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.**

**(h) Notwithstanding subsection (e), an individual policy of accident and sickness insurance may not contain a waiver of coverage for a mental health condition.**

SECTION 5. IC 27-8-5-19.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: **Sec. 19.2. (a) This section applies to a group policy of accident and sickness insurance:**

**(1) that is not employer based;**

**(2) that covers the members of an association or discretionary group; and**

**(3) under which a certificate of coverage is issued to an individual member of the association or discretionary group.**

**(b) Notwithstanding section 19 of this chapter, a policy described in subsection (a) may contain a waiver of coverage for a specified condition and complications that arise from the specified condition if:**

**(1) the period for which the exemption would be in effect does not exceed five (5) years; and**

**(2) all of the following conditions are met:**

**(A) The insurer provides to the applicant before issuance of the policy a written notice explaining the waiver of coverage for the specified condition and complications arising from the specified condition, including a specific description of each condition, complication, service, and treatment for which coverage**

**is being waived.**

**(B) The:**

**(i) offer of coverage; and**

**(ii) certificate of coverage;**

**include the waiver in a separate section stating in bold print that the applicant is receiving coverage with an exception for the waived condition and specifying each related condition, complication, service, and treatment for which coverage is waived.**

**(C) The:**

**(i) offer of coverage; and**

**(ii) certificate of coverage;**

**do not include more than two (2) waivers.**

**(D) The waiver period is concurrent with and not in addition to any applicable preexisting condition limitation or exclusionary period.**

**(E) The insurer agrees to:**

**(i) review the underwriting basis for the waiver upon request one (1) time per year; and**

**(ii) remove the waiver if the insurer determines that evidence of insurability is satisfactory.**

**(F) The insurer discloses to the applicant that the applicant may decline the offer of coverage, and any individual to whom the waiver would have applied may apply for a policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.**

**(G) The waiver of coverage does not apply to coverage required under state law.**

**(c) The insurer shall require an applicant to initial the written notice provided under subsection (b)(2)(A) and the waiver included in the offer of coverage and in the certificate of coverage under subsection (b)(2)(B) to acknowledge acceptance of the waiver of coverage.**

**(d) An insurer shall not, on the basis of a waiver contained in a policy as provided in this section, deny coverage for any condition, complication, service, or treatment that is not specified as required in the:**

**(1) written notice under subsection (b)(2)(A); and**

**(2) offer of coverage and certificate of coverage under subsection (b)(2)(B).**

**(e) An individual who is covered under a policy that includes a waiver under this section may directly appeal a denial of coverage based on the waiver by filing a request for an external grievance review under IC 27-8-29 without pursuing a grievance under IC 27-8-28.**

**(f) An offer of coverage under a policy that includes a waiver under this section does not preclude eligibility for an Indiana comprehensive health insurance association policy under IC 27-8-10-5.1.**

**(g) Notwithstanding subsection (b), a policy described in**

**subsection (a) may not contain a waiver of coverage for a mental health condition.**"

Page 16, between lines 14 and 15, begin a new paragraph and insert:

"SECTION 8. IC 27-8-10-5.1, AS AMENDED BY P.L.233-1999, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 5.1. (a) Except as provided in subsections (b) and (c), a person is not eligible for an association policy if, at the effective date of coverage, the person has or is eligible for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana as set forth in IC 27. **However, an offer of coverage described in IC 27-8-5-2.5(e) or IC 27-8-5-19.2(b) does not affect an individual's eligibility for an association policy under this subsection.** Coverage under any association policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(b) Except as provided in IC 27-13-16-4, a person is eligible for an association policy upon a showing that:

(1) the person has been rejected by one (1) carrier for coverage under any insurance plan that equals or exceeds the minimum requirements for accident and sickness insurance policies issued in Indiana, as set forth in IC 27, without material underwriting restrictions;

(2) an insurer has refused to issue insurance except at a rate exceeding the association plan rate; or

(3) the person is a federally eligible individual.

For the purposes of this subsection, eligibility for Medicare coverage does not disqualify a person who is less than sixty-five (65) years of age from eligibility for an association policy.

(c) The board of directors may establish procedures that would permit:

(1) an association policy to be issued to persons who are covered by a group insurance arrangement when that person or a dependent's health condition is such that the group's coverage is in jeopardy of termination or material rate increases because of that person's or dependent's medical claims experience; and

(2) an association policy to be issued without any limitation on preexisting conditions to a person who is covered by a health insurance arrangement when that person's coverage is scheduled to terminate for any reason beyond the person's control.

(d) An association policy must provide that coverage of a dependent unmarried child terminates when the child becomes nineteen (19) years of age (or twenty-five (25) years of age if the child is enrolled full-time in an accredited educational institution). The policy must also provide in substance that attainment of the limiting age does not operate to terminate a dependent unmarried child's coverage while the dependent is and continues to be both:

(1) incapable of self-sustaining employment by reason of mental retardation or mental or physical disability; and

(2) chiefly dependent upon the person in whose name the contract is issued for support and maintenance.

However, proof of such incapacity and dependency must be furnished to the carrier within one hundred twenty (120) days of the child's attainment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

(e) An association policy that provides coverage for a family member of the person in whose name the contract is issued must, as to the family member's coverage, also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the person in whose name the contract is issued from the moment of birth. The coverage for newly born children must consist of coverage of injury or illness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for the child, the contract may require that notification of the birth of a child and payment of the required premium must be furnished to the carrier within thirty-one (31) days after the date of birth in order to have the coverage continued beyond the thirty-one (31) day period.

(f) Except as provided in subsection (g), an association policy may contain provisions under which coverage is excluded during a period of three (3) months following the effective date of coverage as to a given covered individual for preexisting conditions, as long as medical advice or treatment was recommended or received within a period of three (3) months before the effective date of coverage. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(g) If a person applies for an association policy within six (6) months after termination of the person's coverage under a health insurance arrangement and the person meets the eligibility requirements of subsection (b), then an association policy may not contain provisions under which:

(1) coverage as to a given individual is delayed to a date after the effective date or excluded from the policy; or

(2) coverage as to a given condition is denied;

on the basis of a preexisting health condition. This subsection may not be construed to prohibit preexisting condition provisions in an insurance policy that are more favorable to the insured.

(h) For purposes of this section, coverage under a health insurance arrangement includes, but is not limited to, coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985.

SECTION 9. IC 27-8-29-6, AS ADDED BY P.L.203-2001, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 6. As used in this chapter, "external grievance" means the independent review under this chapter of a:

**(1)** grievance filed under IC 27-8-28; **or**

**(2) denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2.**

SECTION 10. IC 27-8-29-12, AS ADDED BY P.L.203-2001,

SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 12. An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

(1) an adverse determination of appropriateness;

(2) an adverse determination of medical necessity; ~~or~~

(3) a determination that a proposed service is experimental or investigational; **or**

**(4) a denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;**

made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

SECTION 11. IC 27-8-29-13, AS ADDED BY P.L.66-2001, SECTION 3, AND AS ADDED BY P.L.203-2001, SECTION 14, IS AMENDED AND CORRECTED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2002]: Sec. 13. (a) An external grievance procedure established under section 12 of this chapter must:

(1) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's:

**(A)** appeal resolution under IC 27-8-28-17; **or**

**(B) denial of coverage based on a waiver described in IC 27-8-5-2.5 or IC 27-8-5-19.2;**

not more than forty-five (45) days after the covered individual is notified of the resolution; and

(2) provide for:

(A) an expedited external grievance review for a grievance related to an illness, *a* disease, *a* condition, *an* injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A).

A covered individual may file not more than one (1) external grievance of an insurer's appeal resolution under this chapter.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(1) select a different independent review organization for each external grievance filed under this chapter from the list of independent review organizations that are certified by the department under section 19 of this chapter; and

(2) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this chapter may not

have a material professional, familial, financial, or other affiliation with any of the following:

(1) The insurer.

(2) Any officer, director, or management employee of the insurer.

(3) The health care provider or the health care provider's medical group that is proposing the service.

(4) The facility at which the service would be provided.

(5) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed *for use* by the treating health care provider.

(6) The covered individual requesting the external grievance review.

*However, the medical review professional may have an affiliation under which the medical review professional provides health care services to covered individuals of the insurer and may have an affiliation that is limited to staff privileges at the health facility, if the affiliation is disclosed to the covered individual and the insurer before commencing the review and neither the covered individual nor the insurer objects.*

(e) A covered individual may be required to pay not more than twenty-five dollars ($25) of the costs associated with the services of an independent review organization under this chapter. All additional costs must be paid by the insurer."

Page 16, after line 19 , begin a new paragraph and insert:

"SECTION 13. [EFFECTIVE JULY 1, 2002] **IC 27-8-5-2.5, as amended by this act, and IC 27-8-5-19.2, as added by this act, apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2002.**

SECTION 14. [EFFECTIVE JULY 1, 2002] **(a) An insurer that issues a policy of accident and sickness insurance that contains a waiver under IC 27-8-5-2.5(e) or IC 27-8-5-19.2, both as added by this act, shall submit to the commissioner of the department of insurance the following information for the reporting periods specified under subsection (b) on a form prescribed by the commissioner:**

**(1) The number of policies that the insurer issued with a waiver.**

**(2) A list of specified conditions that the insurer waived.**

**(3) The number of waivers issued for each specified condition listed under subdivision (2).**

**(4) The number of waivers issued categorized by the period of time for which coverage of a specified condition was waived.**

**(5) The number of applicants who were denied insurance coverage by the insurer because of a specified condition.**

**(b) An insurer shall submit the information required under subsection (a) as follows:**

**(1) Not later than September 1, 2003, for the reporting**

**period July 1, 2002, through June 30, 2003.**

**(2) Not later than September 1, 2004, for the reporting period July 1, 2003, through June 30, 2004.**

**(c) The commissioner of the department of insurance shall compile the information submitted under subsection (b) and, not later than November 1, 2004, report the information to the senate insurance and financial institutions committee and the house insurance, corporations, and small business committee.**

**(d) This SECTION expires June 30, 2005.**"

Renumber all SECTIONS consecutively.

(Reference is to ESB 276 as printed February 19, 2002.)

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Representative TORR